PRIME SURGERY CENTER

Financial Policy/Conditions of Service Agreement

We would like to thank you for choosing Prime Surgery Center as your health care facility. Our primary concern is that you receive the most appropriate treatment to restore and maintain your good health. Understanding your financial responsibilities and expectations will save you worry and stress later. If you have any questions or concerns about our payment policies, please ask to speak with a financial counselor either by telephone or in person.

It is important that you read this policy carefully before you receive treatment. Insurance co-payments and deductibles are due prior to receiving treatment.

Payment for all services not covered by insurance is due at the time of service. We accept cash, check, and, for your convenience, Visa, MasterCard, Discover and American Express. We will also bill your insurance carrier as a courtesy to you. If you are not covered by Medicare, Medicaid, or a health maintenance organization (HMO) plan contracted with the facility, you must understand the provisions set forth below:

Your policy is an agreement between you and the insurance company. At times, even insurance companies that have a contract with the facility do not pay in a timely manner.

If the insurance company has not paid your bill in full within 45 days, we ask that you contact them to facilitate payment.

All charges are your responsibility whether the insurance company pays or not. Not all services are a covered benefit. Our primary contract is with you and not the insurance company.

You will receive a facility bill from Prime Surgery Center for today's visit. This bill is for the center charges only. You will receive a separate bill from the physician or any other service providers that were involved. All the charges are separate. If you have any questions before signing this agreement, please notify the registration person you are working with.

We understand that things do happen, and financial problems may affect your ability to pay the bill in full. We will always do everything we can to work with you. However, we ask that you contact us as soon as possible to work out an arrangement that is satisfactory for everyone. We appreciate your faith and trust in us and thank you for the opportunity to serve your health care needs.

Assignment and release: I authorize payment to be made directly to Prime Surgery Center and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of all information required to collect and process my claims. If legal action becomes necessary, I agree to pay all collection fees.

Release of Information

The surgery center will obtain the patient's consent and authorization to release medical information, other than basic information concerning the patient, except in those circumstances when the Center is permitted or required by law to release information. The surgery center is authorized, without further action by or on behalf of the patient, to disclose all or any part of the patient's record to any entity, which is or may be liable to the surgier center, patient or any entity affiliated with patient for all or part of the surgery center's or surgery center-based physician's charges for the patient's services including, without limitation, surgery center or medical service companies, insurance companies, worker's compensation carriers, welfare funds, patient's employer or medical utilization review organization designated by the foregoing.

Personal Valuables

We recommend not bringing any valuable belongings with you. If you forget we will give those items to your family or representative of your choice. The center will not be responsible for valuable belongings. We do provide storage locker with locks for the convenience of storing your clothing.

Financial Obligations

The undersigned agrees that in return for the services to be rendered for the patient, the undersigned hereby individually obligates himself/herself to pay the account of the surgery center in accordance with the regular rates and terms of the surgery center. However, if the patient is eligible to receive benefits under a health care service plan with which this surgery center has contracted, the patient shall not be obligated to pay for services covered under the plan which are paid for pursuant to the contract. If any excess funds remain after payment in full of the charges for services rendered for this surgery center visit, the undersigned hereby authorizes the surgery center to apply such excess funds toward any other outstanding account(s) which the patient may have with surgery center for any prior services rendered and for which the undersigned is responsible. Should the patient's account become delinquent and be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

Assignment of Insurance or Health Plan Benefits to Prime Surgery Center

The undersigned authorizes, whether he/she signs as agent or as patient, direct payments to the surgery center of any insurance benefits otherwise payable to or on behalf of the patient for this outpatient services, including emergency services, if rendered. It is agreed that payment to the surgery center, pursuant to this authorization, by an insurance company, shall discharge said insurance company of all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Assignment of Insurance of Health Plan Benefits to Prime Surgery Center Based Physicians

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any surgery center- based physician of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this outpatient services, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Medicare Patient's Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign for the unpaid charges of the physician(s) for whom the surgery center is authorized to bill in connection with its services, I understand I am responsible for any remaining balance not covered by other insurances.

Financial Responsibility Agreement by Person Other than the Patient or Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations (paragraph 7) and Assignment of Insurance or Health Plan Benefits (paragraphs 8 & 9) set forth above.

____ Patient Rights & Privacy/Responsibilities - including complaints and grievances process.

____ Information regarding Advance Directives Information and regarding that this is a physician owned facility.

____ ____________

Responsible party signature date

____ ____________

Please print responsible party name witness initials

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Account number